MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

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9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
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JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Criteria for evaluating potential changes to the Medicare benefit package
-- Mae Thamer

DR. THAMER: I'm here to discuss the criteria to evaluate the Medicare benefit package. To start, the way in which the benefit package is design obviously has a significant impact on the health care received by Medicare beneficiaries as well as the cost and sustainability of the program. So devising a systemic approach to evaluate the current benefit package as well as any proposed reforms is critical so that the values that are being considered can be more easily identified, and the tradeoffs inherent in different policy options can be more clearly understood.

We are proposing six criteria to evaluate any proposed changes to the Medicare benefit package. These criteria are financial protection, access to care, efficiency, financial sustainability over time, operational feasibility, and freedom of choice. Before I get into each one I want to say that there are many tradeoffs associated with using these criteria.

For example, some criteria can overlap or contradict one another, depending on the specific proposal. But the utility of applying the criteria lies in making the process of evaluating proposed changes systematic and explicit.

We would like the Commission to provide guidance on the six selected criteria and their definitions. For the remainder of my presentation I'm going to attempt to define and briefly describe each criterion.

The first one, financial protection. Does the Medicare benefit package protect the financial security of enrollees and their families? In other words, does the benefit package provide sufficient coverage to all beneficiaries to ensure that beneficiaries are adequately insured and are not exposed to prohibitively high out-of-pocket costs?

MR. HACKBARTH: Mae, could I just interrupt you for just one second. I've got us in a bit of a time crunch. We're scheduled to run a little bit later today than usual and I know because of plane schedules people will be pinched at the end. Will you help make up for my getting us behind schedule and try to get through this material as quickly as possible? Because I think what you've sent us in advance pretty well frames what we've got to cover here. Thanks.

DR. THAMER: Why don't I then just go through the criteria and just give you, for some of them, examples of how they wouldn't be met, for instance. For example, with financial protection, this criterion wouldn't be met if the benefit package was modified in such a way so that the beneficiaries would have to forgo or delay care, or not fully comply with recommended care because they couldn't afford it.

Next criterion is access to care. Does the benefit package ensure access to medically necessary care in the most appropriate setting? An example here, there's a proposed option to modify the benefit package, would it increase out-of-pocket expenses for the sickest beneficiaries in a way that would make it more difficult for them to afford needed care? In other words, for this criterion, the potential distributional effects of any proposed reforms, it would be very important.

Efficiency. Does the benefit package encourage the purchase of appropriate care at the lowest possible price and minimize

administrative costs? In other words, is the care delivered of high quality, consistent with preferences of patients, and minimizing the use of ineffective or unnecessary services? This would be measured by a proposed reform in terms of the incentives that would be created for beneficiaries to use health services when they're necessary and they're worth their cost.

Financial sustainability over time. This was one that was referred to a lot this morning and yesterday, can the Medicare benefit package be provided without imposing undue burdens on beneficiaries or taxpayers? If the program is so expensive or reforms proposed are so expensive as to place an undue burden on taxpayers or beneficiaries it might be financially and politically unsustainable for the long term. So issues of how much of the national budget to allocate to health care versus other national priorities have to be considered.

Operational feasibility. Can the benefit package be implemented without causing major disruptions to beneficiaries or to providers? It addresses the ease with which any proposed changes could be implemented. Just for an example, if there's a proposed reform, could it make use of the current administrative systems that operate the Medicare program or would it require new mechanisms?

The last criterion is freedom of choice. Does the Medicare benefit package allow beneficiaries to make choices about their health care, and would any changes affect provider participation? This refers to the Medicare statute that explicitly prohibits the government from exercising any supervision or control over the practice of medicine as well as the original legislation which guaranteed all beneficiaries the freedom to use any qualified provider who participated in Medicare.

This really goes to the heart that there are differences among individuals regarding their choice of providers, health care settings, or treatments, and that given resource constraints these choices have varying implications in terms of costs and outcomes. That's it.

MR. HACKBARTH: Thanks, Mae.

DR. ROWE: Mae, just a couple quick points here. I know we want to move along. One is I think we should recognize that if you asked the question, is the Medicare program meeting its needs or how effective is it, that some people might see that in the context of the kinds of questions people say, how's the American health care system versus that of Europe and the measures they use are not the measures you used. They use life expectancy, mortality rates, things like this. You have none of those here.

There have been dramatic reductions in disability in the elderly since Medicare started. Life expectancy at age 65 and 85 have increased dramatically. I don't believe that's because of the Medicare program particularly, but you might at least address some of those issues up front one way or the other and say, we can't do anything about them, or they're secular effects, they're coincident with Medicare.

But one issue I think should be here, the word should appear and it doesn't, is prevention. Because under access to care you specifically say medically necessary care. That sounds like it's treatment for a specific disease. I think that one measure of whether the Medicare program is meeting the needs of the beneficiary population is whether or not they get access to appropriate preventive services. So I would add preventive as well as -- I would at least somehow make it clear you care about that.

MR. HACKBARTH: Jack, on that point, can those two be tied together perhaps under the heading of access to care? It's access to care that will help improve the longevity and reduce the morbidity of this population.

DR. ROWE: That's right. When I saw access to care that's where I expected to see it. But then you went and said specifically, medically necessary. I was concerned that by doing that you were excluding prevention.

DR. THAMER: If we change it to appropriate health care services, getting away from medically necessary?

DR. ROWE: There's no penalty for using the word prevention. It's in fact a good thing. Why not use it? Just say appropriate preventive and diagnostic and treatment services.

DR. THAMER: Right, then we'd have to specify the others, but that's all right.

DR. ROWE: Same number of words.

[Laughter.]

DR. ROWE: I'll bet you a dollar prevention is not in it the next time we see it, but we'll try.

The last thing I would say is, some people would use patient satisfaction with the system as a measure of whether or not it's serving its purpose. Satisfaction of the consumer or the beneficiary is not here anywhere. You may wish to exclude it, but if you do you have to, I think, say why, because somebody will ask.

DR. THAMER: Freedom of choice is not a big enough umbrella?

DR. ROWE: No penalty for using the word satisfaction.

MS. ROSENBLATT: I actually think it's a good list. I like Jack's comments. I have another criterion to add. Jack, maybe you can help me with the words here, but the issue that I think is not there is -- I think Jill previously used mainstream medical care, you hint at it in medically necessary care.

But with the science base changing I think there's another criterion in terms of the benefit structure which is, what should be covered by a social program and what shouldn't. If we add prescription drug should Viagra be covered, should cochlear implants be covered, should LASIK eye surgery be covered? More and more of that kind of stuff is going to confront us as we move through time.

So I think we might be getting into ethical issues there but I think that's something we need to consider.

MR. SMITH: Three very quick comments. I think this list is right. I have trouble with number four. We really don't mean financial sustainability over time. We really mean political sustainability over time. We can spend the money if we choose to spend the money. It's a political decision. There's not objective economic constraint to going to a higher percentage of GDP for health care or simply for Medicare. We need to be careful not to establish some barrier or suggest a barrier which is quantitative.

I do think, given the discussion of yesterday, we need to make sure that when we talk about Medicare and we talk about criteria we set our framework within the entire system. That what we care about is that the system meet these criteria. Medicare is only part of that system, whether it's the supplemental part of it or the Medicaid part of it or the employer paid part of it. But the criteria, what we want out of the system, we want Medicare to encourage the system or to provide that the system meet those criteria.

Then thirdly, I think it's very important in the financial

protection to be specific in the two ways that Joe described: that we have a stop-loss concern and that we have a particular concern -- it relates to the access question -- for low income beneficiaries. That the system ensure that financial protection simply doesn't mean you don't spend too much money out-of-pocket, but it also means that low income folks have got access to the services.

DR. BRAUN: I just realized the word quality isn't in here anyway and I'm just wondering where we can put it. Clearly I think we should have something in there on quality, whether it comes under the access or --

DR. THAMER: Yes, I was going to say, it should come under the access and possibly we could put it under the high quality preventive, diagnostic, and treatment services. But that's a good point.

DR. BRAUN: The point is high quality treatment.

MR. FEEZOR: I haven't quite gotten the wording on this but it seems to me Medicare benefit design -- and I think we probably need to use benefit design as opposed to benefit package. It's a nuance, but if you think about it, not a small one. Also needs to at least facilitate or at least be facile in combining with supplemental efforts. I'm not saying here supplemental insurance. Hear me clearly before I set anybody off. But in fact is something that can be easily attached, maybe by other social programs or that can in fact be used as a base for other social programs.

It's a social insurance program and yet there are many other social programs that probably will be building around it for our aged. I'll come up with a better term but generally that concept I think is a characteristic in terms of any redesign of Medicare that ought to be kept in mind. I'm sorry I don't have a better idea on that right now.

The other thing is just the issue of freedom of choice. That's a loaded term. How about just choice and how we deal with, whether it's choice of provider or choice even of maybe even some benefits.

DR. WAKEFIELD: Mae, I just want you to draw your attention to the Crossing the Quality Chasm report that might inform your thinking. I'm not going to explicate the bridges that I see. I worked on the committee that crafted that report at the IOM, but I do see different places where it could jump-start some of the thinking even here in terms of the proposals there for redesigning the health care system at large.

There actually are some pieces of that that I think fit nicely with what was said yesterday morning by the panel, the summary of that group that collectively came to some recommendations about how to improve the benefit package. That actually flowed in some interesting way in a parallel fashion to some of the recommendations in the IOM report.

You can target quality different places but where I saw it when I read your text was, purchase of appropriate care. It doesn't matter much to me where it goes, it's just that we hit hard where we can and draw on maybe some of that work where a tremendous amount of effort has already gone before us and informing that more broadly thinking about quality, reflecting that here. If I can help you in any way with that I'd be happy to do it.

MR. HACKBARTH: Yesterday we spent time, aided by Alice and Bob, talking about different views of the supplemental market and whether it could be done differently, more efficiently, more

effectively by bringing all the resources together and providing government coverage in lieu of having it done through a patchwork of private. As I listen to that discussion and think about how it might be received on Capitol Hill, a lot of people would characterize that as a discussion about the appropriate roles of the government and the private sector in financing, and in this case, providing coverage.

I'm not sure where that fits in this set of criteria. I know for some people on the Hill that's a very important criterion, is the respective roles of the private sector and the government. Can we, should we somehow have this on this list of criteria?

DR. THAMER: We had initially considered that under efficiency. That is where, does the benefit package encourage the purchase of appropriate care at the lowest possible cost and minimize administrative costs. It's buried within that verbiage. That was our intent, and minimizing the administrative costs would address the larger issue. But what you're bringing up is a different way to look at it.

MR. HACKBARTH: I welcome thoughts from other people about that. I'm not sure that characterizing it as a matter of administrative efficiency really would capture the concern that people would feel, or the passion they might feel about the issue.

DR. REISCHAUER: I think Mae's description here says there are trade-offs between these criteria. On the one hand efficiency pushes you in one direction, and choice and consumer satisfaction, and the desire to have innovation pushes you in another. So I think it's really in several of these.

DR. ROSS: There is probably a school of thought up on the Hill who would distinguish between the economies of scale in expanding the government role here and not immediately assume that to be more efficient in the long run if it doesn't respond to market changes.

MS. ROSENBLATT: I don't think administrative efficiency really gets at it because you're talking about the smaller piece of the health care dollar. You still have the larger piece on claim cost, the smaller piece on admin, so I think it's inappropriate to look at it that way. But I do think the way you word it, financial sustainability over time, in terms of payroll burden is probably the right way to deal with the Med supp.

MR. HACKBARTH: Bob, as I think about what you just said, let me tell you what I hear you saying, is that actually we attach in the political debate these big labels to these things, public versus private, and people become impassioned about them. Maybe that's diffused somewhat if you break it down below those big labels and look at it as tradeoffs among various criteria as opposed to work with the big labels. Is that what you're suggesting?

DR. REISCHAUER: I think so. But just to show you where I am on this, which I think most of you know, I'm for a significantly expanded benefit package delivered through a premium support system. So it has a very significant role for private sector entities, but at the same time it has a mandated benefit package that is very different and much more comprehensive than the one we have now. So I don't think these things are as closely tied as your original suggestion implied.

MR. HACKBARTH: One other thing I wanted to touch on, going back to David's comment about financial sustainability, and it's really not a matter of finances but rather of will and political

sustainability. I'd welcome some discussion of that point.

MS. ROSENBLATT: I think you can deal with that issue by showing what the choices lead to, but I think that's going to be very difficult to do in the framework. If we end up with payroll taxes doubling over the next 10 years, that's certainly a possibility, but people need to see that's what's going to happen. So my concern with lessening that is not making that point somehow.

MR. HACKBARTH: Murray, what was your take on that or your concern about it?

DR. ROSS: I think it gets to a fundamental question and it's ability to pay versus willingness to pay. I guess one way to think about it, Alice, we're not going to try to do 75-year cost-outs for different benefit packages. This is something that's going to be handled in text as an issue that is going to confront any set of choices you make.

I guess we can handle it by both talking about the trustees' projections on, here's the general issue of what this is going to cost and then recognize that there's a political dimension to it and deciding about, at least cost under current law assumptions. Then there's a political question of what do you want to do about it and who do you want to pay for that. I think we can handle it.

I accepted your distinction, David, between the political decision versus these numbers aren't given by God. So I think we can handle that but it does raise an issue that I guess we had treated a little bit too simply in our thinking.

DR. REISCHAUER: There's a question of what the counterfactual is here. It's not the burden that we're experiencing now. If government doesn't pay for it socially through taxes, individuals are going to pay for it through supplementary premiums or adequate benefits are not going to be delivered. We can't pretend that the situation we're in right now can persist because it can't. It's a question of choosing among not wonderful alternatives.

DR. ROSS: It's not just appropriate benefits or appropriate care being consumed but also a question of how much additional, depending on how you finance it.

MR. HACKBARTH: The distributive implications are greatly different.

DR. LOOP: I understand the components here and I think the discussion is good. But assuming that we order that drink, what are we going to do? Are you going to redesign Medicare or are we going to stick to a more comprehensive benefit package? I'm not quite sure what direction we're going to do after we get to the point of ordering the drink.

MR. HACKBARTH: I'm not sure that I can pursue the bar analogy in those terms. What I envision, based on our earlier discussion, is that actually Bob's suggestion about thinking about this or framing it as if we were to start over we would face some alternative paths that we might choose among. So try to remove ourselves from the specifics of the current Medicare benefit package and say, if we were to start from scratch, where would we go in pursuit of achieving these criteria?

There are I don't know how many alternative paths and decision nodes that we would deal with, but we'd try to lay those out, at least at a gross level and say, here are the strengths and weaknesses of those different choices, potential choices. So that's what we're trying to accomplish at this step.

DR. REISCHAUER: But then the next tab has in it a number of

very specific suggestions about how the benefit package might be changed. Most of them lead to increased cost and I'm not sure we have to go much further than to say, some combination of either increased premiums and higher coinsurance elsewhere could be used to pay for this if one wanted to keep this within a budget constraint.

MR. HACKBARTH: Did we even graze your question?

DR. LOOP: I was trying to get us to commit to either thinking ideologically or politically here. I think maybe the next tab will get us on one track or the other.

MR. HACKBARTH: Is there another choice? Can we think analytically or philosophically?

DR. REISCHAUER: Spiritually?

[Laughter.]

DR. NEWHOUSE: At the risk of being the uninvited guest, I am concerned about some of our language with we're hiding some issues with using appropriate care and medically necessary care. Alice touched on this with her comment about technology, but it's really beyond that. There's lots of care that provides positive benefits to people but isn't necessarily worth its cost. What these words actually mean is somewhat in the eye of the beholder, and we use them as if they have a meaning.

I'd offer, for example, do you do a diagnostic test such as a scan if the probability of finding something is positive but very small? What's medically necessary in that case? I admit that almost everybody uses these words, but I think maybe we should point out there's at least some ambiguity here.

MR. HACKBARTH: I absolutely agree with your point. I'm not sure it's an issue that we will be able to resolve here. In fact I know it's an issue we can't resolve here but we ought to allude to it.

The issue that I heard Alice raising was about things that have a clear benefit but the question is whether it's a benefit we wish to buy. Viagra might be an example that -- I know we wrestled with it at Harvard Community Health Plan, and many others did. Big cost, certainly initially, but is this an essential benefit. There are many others like that.

MS. ROSENBLATT: The point I'm trying to make is where is the cutoff between what is elective, so to speak, and what is provided to everyone.

DR. NEWHOUSE: My point is actually that's a much bigger question because there's many services, procedures, devices and so forth where one would say, absolutely for some people these should be part of the benefit package, but for other people the very same service might have a very modest benefit and should not be.

MR. HACKBARTH: Agreed.

MS. ROSENBLATT: I guess just the other part of what I'm raising is, and I think cochlear implant is a great example, is you can help someone here with a hearing aid or you can help them here with a cochlear implant. Big difference in cost and how do you make that distinction?

DR. LOOP: Before we move on, I think we have to be very practical though about some of these criteria and limit this to the program sustainability, access, and choice, and financial protection at the limits. The other criteria are sort of words, you know, efficiency, and program feasibility. I think we ought to stick to a few core criteria here no matter what direction we go later on.

MR. SMITH: Just back to Joe and Alice's comments for a

minute. I think the distinction, Joe, isn't between whether or not it ought to be in the benefit package or not, but whether or not it ought to be delivered. The word we need to wrestle with here is appropriate.

DR. NEWHOUSE: And medically necessary.

MR. SMITH: And medically necessary. But it's not a question of what ought to be in the benefit package. Alice raises an appropriate --

DR. NEWHOUSE: Except insofar as we use that to say medically necessary should be in the benefit package.

MR. SMITH: But medically necessary ought be in the benefit package. There are some things -- Viagra is a good example -- that maybe ought not to be in the benefit package. That's exactly the appropriate market for consumer choice and supplemental. Both those are two different -- we talked about it as if they were the same distinction. I don't think that's right.

What we want to make sure is that medically appropriate care, medically necessary care is covered in the benefit package and that some things don't fit into that basket and they ought to be outside of the benefit package.

MR. HACKBARTH: We need to move on. I think we've got a good start on the criteria list. I think one of the problems you always have when you're dealing with criteria like this is that in many cases they're subjective. There aren't readily available metrics to measure how well you're accomplishing one versus another and make tradeoffs, et cetera.

I think at this point the best thing we can do is take this list and flesh them out further, make them as concrete as we can. Maybe as we go through that, Floyd, we will see opportunity to condense or reduce. I don't want to condense too quickly though because I think you run the risk of losing credibility if you quickly become a lumper as opposed to a splitter and your reading audience thinks that things that are important to them just haven't been considered at all. So there's a delicate balance that needs to be struck.

MS. NEWPORT: Glenn, I'm sorry, I'll only take a moment. In statute there are terms of art around medical necessity benefit interpretation. I'm happy as a sidebar with the staff to walk through. There's a tiered structure. The way to look at it, which I think will create some safety in terms of people's comfort in the discussion around these things, they're actually legal terms and the structures and implementation are pretty clear, which gets to how do you include more efficient services and what are the options.

So I can walk through a structure for people and then they may be able to come back and answer some questions that have been raised here.

MR. HACKBARTH: Thank you, Mae.